

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036252

5022

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED SEP 27 1963

VS 300
Rev. 4/591
28122

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 41 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cliff Park Nursing Home		d. STREET ADDRESS (If outside, give location) 1426 37th Ave.,	
3. NAME OF DECEASED (Type or print) First BESSE Middle LENA Last KAYLOR		4. DATE OF DEATH Month 9 - Day 13 - Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country). Nevada, Missouri	
13a. FATHER'S NAME George Bunker		14. NAME OF HUSBAND OR WIFE George Anson Kaylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral thrombosis with left hemiplegia DUE TO (c) General + cerebral arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mo under.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 7:50 a.m. Month, Day, Year 6/24/63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION 9/13/63
21. I attended the deceased from 6/24/63 to 9/13/63 and last saw her alive on 9/10/63 Death occurred at 7:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Robert E. Smith	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9-16-1963	23c. NAME OF CEMETERY OR CREMATORY Highland Park Cemetery
24. FUNERAL DIRECTOR Werner Mortuary		25. DATE RECD. BY LOCAL REG. 9-13-63	26. REGISTRAR'S SIGNATURE Bessie Smith
23d. LOCATION (City, town, or county) Kansas City		23e. STATE Kans.	

USE BLACK INK
OR
TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ronald E. Werner

Licensed Embalmer No. 5007

P. O. Address Kans City, Kansas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.